

Reproductive Health Services

How does HRSA define reproductive health services?

[WAC 388-532-001]

HRSA defines reproductive health services as those services that:

- Assist clients to avoid illness, disease, and disability related to reproductive health;
- Provide related and appropriate, medically-necessary care when needed; and
- Assist clients to make informed decisions about using medically safe and effective methods of family planning.

Provider Requirements [Refer to WAC 388-532-110]

To be paid by HRSA for reproductive health services provided to eligible clients, physicians, and advanced registered nurse practitioners (ARNPs) must:

- Meet the requirements in [Chapter 388-502 WAC](#) *Administration of Medical Programs - Providers*;
- Provide only those services that are within the scope of their licenses;
- Educate clients on Food and Drug Administration (FDA)-approved prescription birth control methods and over-the-counter (OTC) birth control supplies and related medical services;
- Provide medical services related to FDA-approved prescription birth control methods and OTC birth control supplies upon request; and
- Prescribe FDA-approved prescription birth control methods and OTC birth control supplies upon request.

Note: Providers who are unable to meet all of the requirements above must refer the client to an appropriate provider.

See the *HRSA-Approved Family Planning Providers Billing Instructions* for more information on how to become an HRSA-approved family planning provider and more information on the Family Planning Only program. Clients enrolled in an HRSA managed care organization may self refer outside their plan for abortions.

Who is eligible? [Refer to WAC 388-532-100(1)]

HRSA covers limited, medically necessary reproductive health services for clients presenting DSHS Medical Identification (ID) cards with one of the following identifiers:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program
CNP - CHIP	CNP – Children’s Health Insurance Program
GAU No Out of State Care	General Assistance Unemployable
General Assistance	ADATSA
LCP-MNP	Limited Casualty Program-Medically Needy Program

Note: Family Planning Only clients are **only** eligible to receive services that are related to the prevention of unintended pregnancy and for sterilizations. They are **not** eligible for other reproductive health services that include maternity care and abortion.

Limited Coverage:

- HRSA covers reproductive health services under Emergency Medical Only programs **only** when the services are directly related to an emergency medical condition.
- HRSA pays only Medicare premium copays, coinsurance, and deductibles for Qualified Medicare Beneficiary clients.

What services are covered? [Refer to WAC 388-532-120]

Services for Women

- **Cervical, vaginal, and breast cancer screening examination**, once per year as medically necessary. The screening CPT code G0101 should be billed with one of the following diagnosis codes:
 - ✓ V72.31 routine gynecological exam with pap cervical smear;
 - ✓ V76.47 routine vaginal pap smear; or
 - ✓ V76.2 cervical pap smear without general gynecological exam.

You may also bill an office visit on the same day using modifier 25, when you provided a separately identifiable Evaluation and Management (E/M) service.

Note: All services provided to Family Planning Only clients must have a primary focus and diagnosis of family planning (the ICD-9-CM V25 series diagnosis codes, excluding V25.3).

Note: HRSA does not pay for preventive health exams for clients 21 years of age and older.

- **FDA-approved prescription contraception method**
(see HRSA's *Prescription Drug Program Billing Instructions*);
- **OTC contraceptives, drugs, and supplies**
(see HRSA's *Prescription Drug Program Billing Instructions*);
- **Maternity-related services;**
- **Abortions;**
- **Sterilization procedures when:**
 - ✓ Requested by the client; and
 - ✓ Performed in an appropriate setting for the procedure.

(See page H.23 for instructions)

Note: The surgeon's initial office visit for sterilization is covered when billed with ICD-9-CM diagnosis code V25.2. The federally mandated sterilization consent form must be filled out at least 30 days prior to the surgery.

Services for Women (continued)

- **Screening and treatment for STD-I**, including laboratory tests and procedures;

Note: For HIV testing use CPT 86703. **HRSA does not cover HIV testing and counseling for Family Planning Only clients.**

- **Education** for FDA-approved contraceptives, natural family planning, and abstinence;
- **Screening mammograms (CPT 76092 and add-on CPT 76083)** for clients 40 years of age and older, once per calendar year. Clients 39 years of age and younger require prior authorization (see section I).
- **Colposcopy** and related medically necessary follow-up services.

Services for Men

HRSA covers the following reproductive health services for men:

- **Office visits** where the primary focus and diagnosis is contraceptive management (including vasectomy counseling) and/or where there is a medical concern;
- **OTC contraceptives, drugs, and supplies** (as described in HRSA's *Prescription Drug Program Billing Instructions*);
- **Sterilization procedures when:**
 - ✓ Requested by the client; and
 - ✓ Performed in an appropriate setting for the procedure.

(See page H.23 for instructions)

Note: The physician's initial office visit for sterilization is covered when billed with ICD-9-CM diagnosis code V25.2. The federally mandated sterilization consent form must be filled out at least 30 days prior to the surgery.

- **Screening and treatment for STD-I**, including laboratory tests and procedures;

Note: For HIV testing use CPT 86703.

- **Education** for FDA-approved contraceptives, natural family planning, and abstinence; and

Physician-Related Services

- **Prostate cancer screening** for men when ordered by a physician, physician assistant, or ARNP. See *Billing* section specifics.

Note: HRSA does not pay for preventive health exams for clients 21 years of age and older.

Physician Services Provided to Clients on the Family Planning Only Program

What is the purpose of the Family Planning Only program?

[Refer to WAC 388-532-500]

The purpose of the Family Planning Only program is to provide family planning services at the end of a pregnancy to women who received medical assistance benefits during their pregnancy.

The primary goal of the Family Planning Only program is to prevent an unintended subsequent pregnancy. Women receive this benefit automatically regardless of how or when the pregnancy ends. This 10-month benefit follows the 60-day postpregnancy coverage by HRSA. **Men are not eligible for the Family Planning Only program.**

When the pregnant woman applies for medical assistance, the Community Services Office (CSO) worker identifies the woman's expected date of delivery. At the end of the 60-day postpartum period, the woman automatically receives an informational flyer and a Medical ID card stating *FAMILY PLANNING ONLY*. If her pregnancy ends for any reason other than delivery, she **must** notify the CSO to receive the Family Planning Only Medical ID card.

Provider Requirements [Refer to WAC 388-532-520]

To be paid by HRSA for services provided to clients eligible for the Family Planning Only program, physicians and advanced registered nurse practitioners (ARNPs) must:

- Meet the requirements in Chapter 388-502 WAC, *Administration of Medical Programs - Provider* rules;
- Provide only those services that are within the scope of their licenses;
- Educate clients on Food and Drug Administration (FDA)-approved prescription birth control methods and over-the-counter (OTC) birth control supplies and related medical services;
- Provide medical services related to FDA-approved prescription birth control methods and OTC birth control supplies upon request; and
- Prescribe FDA-approved prescription birth control methods and OTC birth control supplies upon request.

Note: Providers who are unable to meet all of the provider requirements must refer the client to an appropriate provider.

Who is eligible? [WAC 388-532-510]

A woman is eligible for Family Planning Only services if:

- She received medical assistance benefits during her pregnancy; or
- She is determined eligible for a retroactive period (see Definitions section) covering the end of the pregnancy.

What services are covered? [Refer to WAC 388-532-530]

Note: All services provided to Family Planning Only clients must have a primary focus and diagnosis of family planning (the ICD-9-CM V25 series, excluding V25.3).

HRSA covers the following services under the Family Planning Only program:

- **Cervical, vaginal, and breast cancer screening examination**, once per year as medically necessary. The examination must be:
 - ✓ Provided according to the current standard of care; and
 - ✓ Conducted at the time of an office visit with a primary focus and diagnosis of family planning (ICD-9-CM V25 series diagnosis codes, excluding v25.3).
- **FDA-approved prescription contraception methods**
(see HRSA's *Prescription Drug Program Billing Instructions* for requirements)
- **OTC contraceptives, drugs, and supplies**
(see HRSA's *Prescription Drug Program Billing Instructions*)
- **Sterilization** procedures that meet the requirements of HRSA's *Physician-Related Services Billing Instructions*, if it is:
 - ✓ Requested by the client; and
 - ✓ Performed in an appropriate setting for the procedure.

Note: The surgeon's initial office visit for sterilization is covered when billed with ICD-9-CM diagnosis code V25.2. The federally mandated sterilization consent form must be filled out at least 30 days prior to the surgery.

- **Screening and treatment for STD-I**, including laboratory tests and procedures only when the screening and treatment is:
 - ✓ Performed in conjunction with an office visit that has a primary focus and diagnosis of family planning (ICD-9-CM V25 series diagnosis codes, excluding v25.3); and
 - ✓ Medically necessary for the client to safely, effectively, and successfully use, or continue to use, her chosen contraceptive method.
- **Education** for FDA-approved contraceptives, natural family planning, and abstinence.

What drugs and supplies are paid under the Family Planning Only program?

HRSA pays for the following family planning-related drugs and contraceptives prescribed by a physician:

Absorbable Sulfonamides
Anaerobic antiprotozoal – antibacterial agents
Antibiotics, misc. other
Antifungal Agents
Antifungal Antibiotics
Cephalosporins – 1st generation
Cephalosporins – 2nd generation
Cephalosporins – 3rd generation
Condoms
Contraceptives, injectables
Contraceptives, intravaginal
Contraceptives, intravaginal, systemic
Contraceptives, transdermal
Diaphragms/cervical caps
Intrauterine devices
Macrolides
Nitrofurantoin Derivatives
Oral contraceptives
Quinolones
Tetracyclines
Vaginal Antibiotics
Vaginal antifungals
Vaginal lubricant preparations
Vaginal Sulfonamides

Drugs for Sterilizations

Antianxiety Medication – Before Sterilization Procedure

- Diazepam
- Alprazolam

Pain Medication – After Sterilization Procedure

- Acetaminophen with Codeine #3
- Hydrocodone Bit/ Acetaminophen
- Oxycodone HCl/Acetaminophen 5/500
- Oxycodone HCl/ Acetaminophen

Over-the-counter, non-prescribed contraceptive supplies (e.g., condoms, spermicidal foam, cream, gel, sponge, etc.,) may also be obtained with a Medical ID Card in a 30-day supply through a pharmacy.

Contraceptive hormone prescriptions must be written for three or more months, with a maximum of 12 months, unless there is a clinical reason to write the prescription for less than three months.

Note: All services provided to Family Planning Only clients **must** have a primary focus and diagnosis of family planning (the ICD-9-CM V25 series diagnosis codes, excluding V25.3).

What services are *not* covered? [WAC 388-532-540]

Medical services are not covered under the Family Planning Only program unless those services are:

- Performed in relation to a primary focus and diagnosis of family planning (ICD-9-CM V25 series diagnosis codes, excluding V25.3); and
- Medically necessary for the client to safely, effectively, and successfully use, or continue to use, their chosen contraceptive method.

Abortions are **not** covered under the Family Planning Only program.

Note: If the client's DSHS Medical ID card says *Family Planning Only* but she is pregnant, please refer the client to her local Community Services Office (CSO) to be evaluated for a possible change in her Medical Assistance program that would enable her to receive full scope of care.

Inpatient Services: HRSA does not pay for inpatient services under the Family Planning Only program. However, inpatient costs may be incurred as a result of complications arising from covered family planning services. If this happens, providers of inpatient services must submit a complete report to HRSA of the circumstances and conditions that caused the need for the inpatient services in order for HRSA to consider payment under WAC 388-501-0160.

A complete report includes:

- A copy of the billing (UB-92, HCFA-1500);
- Letter of explanation;
- Discharge summary; and
- Operative report (if applicable).

Fax the complete report to HRSA Division of Medical Management at (360) 586-1471.

Payment [Refer to WAC 388-532-550, WAC 388-530-1425, and WAC 530-1700(4)]

Fee Schedule: HRSA limits payment under the Family Planning Only program to visits and services that:

- Have a primary focus and diagnosis of family planning as determined by a qualified, licensed medical practitioner (ICD-9-CM V25 series diagnosis codes, excluding V25.3); and
- Are medically necessary for the client to safely, effectively, and successfully use, or continue to use, their chosen contraceptive method.

Maternity Care and Delivery

Prenatal Assessments Are Not Covered

HRSA does not cover prenatal assessments. If a client is seen for reasons other than routine antepartum care, providers must bill using the appropriate Evaluation and Management (E&M) procedure code with a medical diagnosis code. E&M codes billed with ICD-9-CM diagnosis codes V22.0-V22.2 will be denied.

Exception: Providers must bill E&M codes for antepartum care if *only* 1-3 antepartum visits are done, as discussed later in these billing instructions.

Confirmation of Pregnancy

If a client presents with signs or symptoms of pregnancy and the purpose of the client's visit is to confirm the pregnancy, bill this visit using the appropriate level E&M code, if the obstetrical (OB) record is not initiated. If the OB record is initiated at this visit, then the visit is considered part of the global OB package and must not be billed separately.

If some other source has confirmed the pregnancy and the provider wants to do his/her own confirmation, bill this visit using the appropriate level E&M code, if the OB record is not initiated. If the OB record is initiated at this visit, the visit is considered part of the global OB package and must not be billed separately.

If the purpose of the client's visit is to confirm the pregnancy and the OB record is not initiated, bill using the diagnosis code(s) for the signs and/or symptoms the client is having [e.g. suppressed menstruation (ICD-9-CM diagnosis code 626.8)]. Do not bill using the pregnancy diagnosis codes (e.g. V22.0-V22.2) unless the OB record is initiated at this visit. If the OB record is initiated at this visit, the visit is considered part of the global package.

Global (Total) Obstetrical (OB) Care

Global OB care (CPT codes 59400, 59510, 59610, or 59618) includes all the following:

- Routine antepartum care in any trimester;
- Delivery; and
- Postpartum care.

If you provide all of the client's antepartum care, perform the delivery, and provide the postpartum care, **you must bill** using one of the global OB procedure codes.

When more than one provider in the same clinic (same group provider number) sees the same client for global maternity care, HRSA pays only one provider for the global (total) obstetrical care.

Providers who are in the same clinic who **do not** have the same group provider number **must not** bill HRSA the global (total) obstetrical care procedure codes. In this case, you must “unbundle” the OB services and bill the antepartum, delivery, or postpartum care separately.

Note: Do not bill HRSA for maternity services until all care is completed.

Unbundling Obstetrical Care

In the situations described below, you may not be able to bill HRSA for global OB care. In these cases, it may be necessary to “unbundle” the OB services and bill the antepartum, delivery, and postpartum care separately, as HRSA may have paid another provider for some of the client’s OB care, or you may have been paid by another insurance carrier for some of the client’s OB care.

When a client transfers to your practice late in the pregnancy...

- If the client has had antepartum care elsewhere, you must not bill the global OB package. Bill the antepartum care, delivery, and postpartum care separately. The provider that had been providing the antepartum care bills for the services that he/she performed. Therefore, if you bill the global OB package, you are billing for some antepartum care that another provider has claimed.

- OR -

- If the client did not receive any antepartum care prior to coming to your office, bill the global OB package.

In this case, you may actually perform all of the components of the global OB package in a short time. HRSA does not require you to perform a specific number of antepartum visits in order to bill for the global OB package.

If your client moves to another provider (not associated with your practice), moves out of your area prior to delivery, or loses the pregnancy...

Bill only those services you actually provided to these clients.

If your client changes insurance during her pregnancy...

Often, a client is fee-for-service at the beginning of her pregnancy and enrolled in an HRSA managed care organization for the remainder of her pregnancy. HRSA is responsible for paying only those services provided to the client while she is on fee-for-service. The managed care organization pays for services provided after the client is enrolled with the plan.

When a client changes from one plan to another, bill those services that were provided while she was enrolled with the original plan to the original carrier, and those services that were provided under the new coverage to the new plan. You must unbundle the services and bill the antepartum, delivery, and postpartum care separately.

Antepartum Care

Per CPT guidelines, HRSA considers routine antepartum care for a normal, uncomplicated pregnancy to consist of:

- Monthly visits up to 28 weeks gestation;
- Biweekly visits to 36 weeks gestation; and
- Weekly visits until delivery.

Antepartum care includes:

- Initial and subsequent history;
- Physical examination;
- Recording of weight and blood pressure;
- Recording of fetal heart tones;
- Routine chemical urinalysis; and
- Maternity counseling, such as risk factor assessment and referrals.

Necessary prenatal laboratory tests may be billed in addition to antepartum care, **except for dipstick tests** (CPT codes 81000, 81002, 81003, and 81007).

Coding for Antepartum Care Only

If it is necessary to unbundle the OB package and bill separately for antepartum care, bill as follows:

- If the client had a **total** of one to three antepartum visits, bill the appropriate level of **E&M service with modifier TH** for each visit, with the date of service the visit occurred and the appropriate diagnosis.

Modifier TH: Obstetrical treatment/service, prenatal or postpartum

- If the client had a **total** of four to six antepartum visits, bill using **CPT code 59425** with a "1" in the units box. Bill HRSA using the date of the last antepartum visit in the "to and from" fields.
- If the client had a **total** of seven or more visits, bill using **CPT code 59426** with a "1" in the units box. Bill HRSA using the date of the last antepartum visit in the "to and from" fields.

Do not bill antepartum care only codes in addition to any other procedure codes that include antepartum care (i.e. global OB codes).

When billing for antepartum care, **do not bill** using CPT E&M codes for the first three visits, then CPT code 59425 for visits four through six, and then CPT code 59426 for visits seven and on. These CPT codes are used to bill only the **total** number of times you saw the client for all antepartum care during her pregnancy, and **may not** be billed in combination with each other during the entire pregnancy period.

Note: Do not bill HRSA until all antepartum services are complete.

Coding for Deliveries

If it is necessary to unbundle the OB package and bill for the delivery only, you must bill HRSA using one of the following CPT codes:

- 59409 (vaginal delivery only);
- 59514 (cesarean delivery only);
- 59612 [vaginal delivery only, after previous cesarean delivery (VBAC)]; or
- 59620 [cesarean delivery only, after attempted vaginal delivery after previous cesarean delivery (attempted VBAC)].

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If you do not provide antepartum care, but perform the delivery and provide postpartum care, bill HRSA one of the following CPT codes:

- 59410 (vaginal delivery, including postpartum care);
- 59515 (cesarean delivery, including postpartum care);
- 59614 (VBAC, including postpartum care); or
- 59622 (attempted VBAC, including postpartum care).

Coding for Postpartum Care Only

If it is necessary to unbundle the OB package and bill for postpartum care only, you must bill HRSA using CPT code 59430 (postpartum care only).

If you provide all of the antepartum and postpartum care, but do not perform the delivery, bill HRSA for the antepartum care using the antepartum care only codes, along with CPT code 59430 (postpartum care only).

Do not bill CPT code 59430 (postpartum care only) in addition to any procedure codes that include postpartum care.

Additional Monitoring for High-Risk Conditions

When providing **additional monitoring** for high-risk conditions in excess of the CPT guidelines for normal antepartum visits, bill using E&M codes **99211-99215 with modifier UA**. The office visits may be billed in addition to the global fee *only after* exceeding the CPT guidelines for normal antepartum care.

A condition that is classifiable as high-risk **alone** does not entitle the provider to additional payment. Per CPT guidelines, it must be medically necessary to see the client **more often** than what is considered routine antepartum care in order to qualify for additional payments. ***The additional payments are intended to cover additional costs incurred by the provider as a result of more frequent visits. For example:***

Client A is scheduled to see her provider for her antepartum visits on January 4, February 5, March 3, and April 7. The client attends her January and February visits, as scheduled. However, during her scheduled February visit, the provider discovers the client's blood pressure is slightly high and wants her to come in on February 12 to be checked again. At the February 12 visit, the provider discovers her blood pressure is still slightly high and asks to see her again on February 18. The February 12 and February 18 visits are outside of her regularly scheduled antepartum visits and outside of the CPT guidelines for routine antepartum care since she is being seen more often than once per month. The February 12 and February 18 visits may be billed separately from the global antepartum visits using the appropriate E&M codes with modifier UA, and the diagnosis must represent the medical necessity for billing additional visits. **A normal pregnancy diagnosis (i.e. V22.0 – V22.2) will be denied outside of the global antepartum care. It is not necessary to wait until all services included in the routine antepartum care are performed to bill the extra visits, as long as the extra visits are outside of the regularly scheduled visits.**

Labor Management

Providers may bill for labor management **only** when another provider (outside of your group practice) performs the delivery. If you performed all of the client's antepartum care, admitted the client to the hospital during labor, delivered the baby, and performed the postpartum care, **do not** bill HRSA for the hospital admission or for labor management. These services are included in the global OB package.

If, however, you performed all of the client's antepartum care and admitted the client to the hospital during labor, but another provider (outside of your group practice) takes over delivery, you must unbundle the global OB package and bill separately for antepartum care, the hospital admission, and the time spent managing the client's labor. The client must be in active labor and admitted to a hospital when the referral to the delivering provider is made.

To bill for labor management in the situation described above, bill HRSA for one of the hospital admission CPT codes **99221-99223 with modifier TH**. In addition to the hospital admission, HRSA pays providers for **up to three hours** of labor management using prolonged services CPT codes **99356-99357 with modifier TH**. Payment for prolonged services is *limited to three hours per client, per pregnancy*, regardless of the number of calendar days a client is in labor, or the number of providers who provide labor management. **Labor management may not be billed by the delivering provider, or by any provider within the delivering provider's group practice.**

Note: The hospital admission code and the prolonged services code(s) **must** be billed on the same claim form.

Note: HRSA pays for labor management only when the provider performs the above services on the same day.

High-Risk Deliveries

Delivery includes management of uncomplicated labor and vaginal delivery (with or without episiotomy, with or without forceps) or cesarean section. If a complication occurs during delivery resulting in an unusually complicated, high-risk delivery, HRSA pays providers an additional add-on fee. Bill the high-risk add-on fee by **adding modifier TG to the delivery code** (e.g. 59400 TG or 59409 TG).

Modifier TG: Complex/high level of care

The ICD-9-CM diagnosis code ***must clearly*** demonstrate the medical necessity for the high-risk delivery add-on (e.g. a diagnosis of fetal distress). A normal delivery diagnosis is not paid an additional high-risk add-on fee, even if the mother had a high-risk condition during the antepartum period.

Bill only *ONE* line of service (e.g. 59400 TG) to receive payment for BOTH the delivery and the high-risk add-on. *DO NOT* bill the delivery code (e.g. 59400) on one line of the claim form and the high-risk add-on (e.g. 59400 TG) on a second line of the claim form.

A physician who provides stand-by attendance for high-risk delivery can bill CPT code 99360 and resuscitation CPT code 99440, when appropriate.

Note: HRSA does not pay an assistant surgeon, RNFA, or co-surgeon for a high-risk delivery add-on. Payment is limited to one per client, per pregnancy (even in the case of multiple births).

Consultations

If another provider refers a client during her pregnancy for a consultation, bill HRSA using consultation CPT codes 99241-99245. If an inpatient consultation is necessary, bill using CPT codes 99251 – 99255 or for a follow-up bill using CPT codes 99231-99233. You ***must*** list the referring physician's name and HRSA- assigned provider number in the "Referring Physician" field on the claim form.

If the consultation results in the decision to perform surgery (i.e. a cesarean section), HRSA pays the consulting physician for the consultation as follows:

- If the consulting physician does not perform the cesarean section, bill HRSA the appropriate consultation code.
- If the consulting physician performs the cesarean section and does the consultation **two or more days prior to the date of surgery**, bill HRSA the appropriate **consultation code with modifier 57** (e.g. 99241-57).

HRSA does not pay the consulting physician if the following applies:

- If the consulting physician performs the cesarean section and does the consultation **the day before or the day of the cesarean section**, the consultation is bundled within payment for the surgery. **Do not bill** HRSA for the consultation in this situation.

Bill consultations with an appropriate ICD-9-CM medical diagnosis code. You must demonstrate the medical necessity (i.e. sign, symptom, or condition). HRSA does not pay providers for a consultation with a normal pregnancy diagnosis code (e.g. V22.0-V22.2).

HRSA pays consulting OB/GYN providers for an external cephalic version (CPT code 59412) and a consultation when performed on the same day.

General Obstetrical Payment Policies and Limitations

- HRSA pays a multiple vaginal delivery (for twins, triplets, etc.) at 100% for the first baby. When billing for the second or third baby, you must bill using the delivery-only code (CPT code 59409 or 59612) for each additional baby. Payment for each additional baby will be 50% of the delivery-only code's maximum allowance. Bill each baby's delivery on a separate line. Identify on the claim form as "twin A" or "twin B," etc.
- HRSA pays for multiple births by cesarean delivery at 100% for the first baby. No additional payment will be made for additional babies.
- A physician may bill for an assist at c-section by adding modifier 80, 81, or 82 to the delivery only code (e.g. 59514-80). Payment is 20% of the delivery-only code's maximum allowance.
- Physician assistants (PA) must bill for an assist at c-section **on the same claim form** as the physician performing the delivery by adding modifier 80, 81, or 82 to the delivery-only code (e.g. 59514-80). The claim must be billed using the delivering physician's provider number.
- RNFAs assisting at c-sections may **only** bill using CPT code 59514 or 59620 with modifier 80.
- To bill for anesthesia during delivery, see the Anesthesia Section (page F.26).
- For deliveries in a birthing center, refer to HRSA's current *Births in Birthing Centers Billing Instructions*. For deliveries in a home birth setting, refer to HRSA's current *Planned Home Births Billing Instructions*.

Note: Maternity Support Services/Infant Case Management (MSS/ICM) is a program designed to help pregnant women and their newborns gain access to medical, social, educational and other services. This program provides a variety of services for both the woman and/or her child in the home or clinic throughout pregnancy and up to 60 days after delivery. For information on MSS/ICM, call HRSA's Family Services Section at (360) 725-1655 (see Important Contacts section).

For your convenience, a table summarizing “Billing HRSA for Maternity Services” is included on the following pages.

**Billing HRSA for Maternity Services
In a Hospital Setting**

Global (Total) Obstetrical (OB) Care

<i>Service</i>	Procedure Code/Modifier	Summary of Description	Limitations
Confirmation of pregnancy	99201-99215	Office visits	Code the sign or symptom (e.g. suppressed menstruation)
Global OB care	59400	Total OB care, vaginal delivery	Includes all antepartum, delivery, and postpartum care; bill after all services are complete; limited to one per client, per pregnancy; additional vaginal deliveries for multiple bills must be billed with the appropriate delivery-only code.
	59510	Total OB care, c-section	
	59610	Total OB care, VBAC	
	59618	Total OB care, attempted VBAC	

Antepartum Care Only

<i>Service</i>	Procedure Code/Modifier	Summary of Description	Limitations
Antepartum care (bill <i>only one</i> of these codes to represent the total number of times you saw the client for antepartum care)	99201-99215 TH	Offices visits, antepartum care 1-3 visits only, with OB service modifier	Limited to 3 units when used for routine antepartum care. Must bill with modifier UA.
	59425	Antepartum care, 4-6 visits	Limited to one unit per client, per pregnancy, per provider
	59426	Antepartum care, 7+ visits	Limited to one unit per client, per pregnancy, per provider.

Deliveries

<i>Service</i>	Procedure Code/Modifier	Summary of Description	Limitations
Delivery only	59409	Vaginal delivery only	Must not be billed with any other codes that include deliveries; assist at c-section must be billed with delivery-only code with modifier 80.
	59514	C-Section delivery only	
	59612	VBAC delivery only	
	59620	Attempted VBAC delivery only	
Delivery with postpartum care	59410	Vaginal delivery including postpartum care	Must not be billed with any other codes that include deliveries; must not be billed with postpartum only code; limited to one per client, per pregnancy; additional vaginal deliveries for multiple births must be billed using the appropriate delivery-only code.
	59515	C-Section delivery with postpartum care	
	59614	VBAC including postpartum care	
	59622	Attempted VBAC including postpartum care	

**Billing HRSA for Maternity Services
In a Hospital Setting**

Postpartum Care Only

<i>Service</i>	Procedure Code/Modifier	Summary of Description	Limitations
Postpartum care only	59430	Postpartum care only	Must not be billed with any other codes that include postpartum care; limited to one per client, per pregnancy.

Additional Monitoring for High-Risk Conditions

<i>Service</i>	Procedure Code/Modifier	Summary of Description	Limitations
Additional visits for antepartum care due to high-risk conditions	99211-99215 UA	Office visits with OB service modifier	Must not be billed with a normal pregnancy diagnosis (V22.0-V22.2); diagnosis must detail need for additional visits; must be billed with modifier UA.

Labor Management

<i>Service</i>	Procedure Code/Modifier	Summary of Description	Limitations
Labor management (may only be billed when another provider takes over and delivers the infant)	99221-99223 TH	Hospital admit services with OB services modifier	Prolonged services are limited to 3 hours per client, per pregnancy; must be billed with modifier TH; must not be billed by delivering provider.
	+99356 Limited to 1 unit	Prolonged services, inpatient setting, 1 st hour	
	+99357 Limited to 4 units	Prolonged services, inpatient setting, each add'l 30 minutes	Admit code with modifier TH and the prolonged services code(s) must be billed on the same claim form.

High-Risk Deliveries

<i>Service</i>	Procedure Code/Modifier	Summary of Description	Limitations
High-risk delivery <i>[Not covered for assistant surgeons, co-surgeons, or RNFA]</i>	Add modifier TG to the delivery code (e.g. 59400 TG)	Complex/high level of care	Diagnosis must demonstrate medical necessity; not paid with normal delivery diagnosis; limited to one per client, per pregnancy. • Bill only ONE line of service (e.g. 59400 TG) for BOTH the delivery and high-risk add-on.

Smoking Cessation for Pregnant Women

HRSA pays providers for smoking cessation counseling as part of an antepartum care visit or a post-pregnancy office visit for tobacco dependent eligible pregnant women.

What is Smoking Cessation Counseling?

Smoking cessation counseling consists of provider information and assistance to help the client stop smoking. Smoking cessation counseling includes the following steps:

- Step 1: Asking the client about her smoking status;
- Step 2: Advising the client to stop smoking;
- Step 3: Assessing the client's willingness to set a quit date;
- Step 4: Assisting the client to stop smoking, which includes a written quit plan. If the provider considers it appropriate for the client, the "assisting" step may also include prescribing smoking cessation pharmacotherapy, as needed (see next page); and
- Step 5: Arranging to track the progress of the client's attempt to stop smoking.

Who is eligible for smoking cessation counseling?

Fee-for-service: Tobacco dependent, pregnant women covered under fee-for-service are eligible for smoking cessation counseling.

Managed Care: Tobacco dependent, pregnant women who are enrolled in a managed care organization must have services arranged and referred by their primary care provider (PCP). Clients covered under a managed care organization will have a plan indicator in the HMO column on their Medical Identification card. Do not bill HRSA for Smoking Cessation Counseling as it is included in the managed care organizations' payment rates.

Who is eligible to be paid for smoking cessation counseling?

HRSA will pay only the following providers for smoking cessation counseling as part of an antepartum care visit or a post-pregnancy office visit (which must take place within two months following live birth, miscarriage, fetal death, or pregnancy termination):

- Physicians;
- Physician Assistants (PA) working under the guidance and billing under the provider number of a physician;
- Advanced Registered Nurse Practitioners (ARNP); and
- Licensed Midwives (LM), including certified nurse midwives (CNM).

What is covered?

HRSA allows one smoking cessation counseling session per client, per day, up to 10 sessions per client, per pregnancy. The provider must keep written documentation in the client's file for each session. The documentation must reflect the information listed on the following page.

HRSA covers two levels of counseling:

- Basic counseling (approximately 3 to 10 minutes) which includes Steps 1-3 on previous page; and
- Intensive counseling (longer than 10 minutes) which includes Steps 1-5 on previous page.

Use the most appropriate procedure code from the following chart when billing for smoking cessation:

CPT Procedure Code	Brief Description	Restricted to Diagnoses:
G0375	(Smoke/Tobacco Counseling 3-10)	648.43 (antepartum) 648.44 (postpartum)
G0376	(Smoke/Tobacco Counseling <10)	648.43 (antepartum) 648.44 (postpartum)

A provider may prescribe pharmacotherapy for smoking cessation for a client when the provider considers the treatment appropriate for the client. HRSA covers pharmacotherapy for smoking cessation as follows:

- HRSA covers Zyban[®] only;
- The product must be prescribed by a physician, ARNP, or PA;
- The client for whom the product is prescribed must be 18 years of age or older;
- The **pharmacy provider must obtain prior authorization** from HRSA when filling the prescription for pharmacotherapy; and
- The provider must include both of the following on the client's prescription:
 - ✓ The client's estimated or actual delivery date; and
 - ✓ Notation that the client is participating in smoking cessation counseling.

To obtain prior authorization for Zyban[®], pharmacy providers must call:

Drug Utilization and Review
1-800-848-2842

Sterilization

What is sterilization? [Refer to WAC 388-531-1550(1)]

Sterilization is any medical procedure, treatment, or operation for the purpose of rendering a client permanently incapable of reproducing. This includes vasectomies and tubal ligations.

Note: HRSA does **not** pay for hysterectomies performed solely for the purpose of sterilization.

What are HRSA's payment requirements for sterilizations?

[Refer to WAC 388-531-1550(2)]

HRSA covers sterilization when all of the following apply:

- The client has **voluntarily** given informed consent;
- The client is at least 18 years of age at the time consent is signed;
- The client is a mentally competent individual; and
- At least 30 days, but not more than 180 days, have passed between the date the client gave informed consent and the date of the sterilization.

Note: HRSA pays providers for sterilizations for managed care clients 18 through 20 years of age under the fee-for-service system. All other managed care clients must obtain their sterilization services from their managed care provider.

HRSA pays providers (e.g., hospitals, anesthesiologists, surgeons, and other attending providers) for a sterilization procedure only when the completed federally approved Sterilization Consent Form, DSHS 13-364, is attached to the claim. Click link to download the DSHS 13-364 http://www1.dshs.wa.gov/pdf/ms/forms/13_364a.pdf. HRSA does not accept any other forms attached to the claim. HRSA pays after the procedure is completed.

HRSA pays providers for epidural anesthesia in excess of the six-hour limit for deliveries if sterilization procedures are performed in conjunction with, or immediately following, a delivery. HRSA determines total billable units by:

- Adding the time for the sterilization procedure to the time for the delivery; and
- Determining the total billable units by adding together the delivery base anesthesia units (BAUs), the delivery time, and the sterilization time.

Do not bill the BAUs for the sterilization procedure separately.

Additional Requirements for Sterilization of Mentally Incompetent or Institutionalized Clients

Providers must meet the following additional consent requirements before HRSA will pay the provider for the sterilization of a mentally incompetent or institutionalized client. HRSA requires both of the following to be attached to the claim form:

- Court orders that include the following:
 - ✓ A statement that the client is to be sterilized; **and**
 - ✓ The name of the client's legal guardian, who will be giving consent for the sterilization.
- Sterilization Consent Form, DSHS 13-364, signed by the client's legal guardian.

When does HRSA waive the 30-day waiting period?

[WAC 388-531-1550(3) and (4)]

HRSA does not require the 30-day waiting period, but does require at least a 72 hour waiting period, for sterilization in the following circumstances:

- At the time of premature delivery, the client gave consent at least 30 days before the *expected* date of delivery. The expected date of delivery must be documented on the consent form.
- For emergency abdominal surgery, the nature of the emergency must be described on the consent form.

HRSA waives the 30-day consent waiting period for sterilization when the client requests that sterilization be performed at the time of delivery, **and** completes a Sterilization Consent Form, DSHS 13-364. One of the following circumstances must apply:

- The client became eligible for Medical Assistance during the last month of pregnancy (**HCFA 1500 field 19: "NOT ELIGIBLE 30 DAYS BEFORE DELIVERY"**); or
- The client did not obtain medical care until the last month of pregnancy (**HCFA 1500 field 19: "NO MEDICAL CARE 30 DAYS BEFORE DELIVERY"**); or
- The client was a substance abuser during pregnancy, but is not using alcohol or illegal drugs at the time of delivery. (**HCFA 1500 field 19: "NO SUBSTANCE ABUSE AT TIME OF DELIVERY."**)

The provider must note on the HCFA-1500 claim form in field 19 or on the backup documentation, which of the above waiver condition(s) has been met. Required language is shown in parenthesis above. Providers who bill electronically, must indicate this information in the *Comments* field.

When does HRSA *not* accept a signed Sterilization Consent Form (DSHS 13-364)? [Refer to WAC 388-531-1550(5) and (6)]

HRSA does not accept informed consent obtained when the client is in any of the following conditions:

- In labor or childbirth;
- Seeking to obtain or obtaining an abortion; or
- Under the influence of alcohol or other substances that affect the client's state of awareness.

Why do I need a DSHS-approved Sterilization Consent Form?

Federal regulations prohibit payment for sterilization procedures until a federally approved and accurately completed Sterilization Consent Form, DSHS 13-364 is received. To comply with this requirement, surgeons, anesthesiologists, and assistant surgeons as well as the facility in which the surgery is being performed must obtain a copy of a completed Sterilization Consent Form, DSHS 13-364, to attach to their claim.

You must use Sterilization Consent Form, DSHS 13-364, in order for HRSA to pay your claim. HRSA does not accept any other form.

To **download** DSHS forms, visit: <http://www1.dshs.wa.gov/msa/forms/eforms.html>
Scroll down to form number 13-364.

To **have a hard copy sent** to you, contact:
DSHS Forms Management Phone: (360) 664-6047 or Fax: (360) 664-6186

Include in your request:

- Form number and name;
- Quantity desired;
- Your name and your office name; and
- Your full mailing address.

HRSA will deny a claim for a procedure received without the Sterilization Consent Form, DSHS 13-364. HRSA will deny a claim with an incomplete or improperly completed Sterilization Consent Form. Submit the claim and completed Sterilization Consent Form, DSHS 13-364, to:

**HRSA Division of Program Support
PO Box 9248
Olympia WA 98507-9248**

If you are submitting your sterilization claim form electronically, be sure to indicate in the comments section that you are sending in a hard copy of the Sterilization Consent Form, DSHS 13-364. Then send in the form with the electronic claims ICN.

Who completes the Sterilization Consent Form (DSHS 13-364)?

- Sections I, II, and III of the Sterilization Consent Form are completed by the client, interpreter (if needed), and the physician/clinic representative more than 30 days, but less than 180 days, prior to date of sterilization. If less than 30 days, refer to page F.2: "When does HRSA waive the 30 day waiting period?" and/or section IV of the Sterilization Consent Form.
- The bottom right portion (section IV) of the Sterilization Consent Form is completed shortly before, on, or after the surgery date by the physician who performed the surgery.
- If the initial Sterilization Consent Form sections I, II, and III are completed by one physician and a different physician performed the surgery:
 - ✓ Complete another Sterilization Consent Form entering the date it was completed; and
 - ✓ Submit both Sterilization Consent Form with your claim.

Frequently Asked Questions on Billing Sterilizations

1. If I provide sterilization services to Family Planning Only clients along with a secondary surgical intervention, such as lysis of adhesions, will I be paid?

The scope of coverage for Family Planning Only clients is limited to contraceptive intervention only. HRSA does not pay for any other medical services unless they are medically necessary in order for the client to safely, effectively and successfully use or continue to use their chosen birth control method.

Only claims submitted with diagnosis codes in the V25 series (excluding V25.3) will be processed for possible payment. All other diagnosis codes are non covered and will not be paid.

Note: Remember you must submit all sterilization claims with the **completed**, federally approved Sterilization Consent Form.

2. If I provide sterilization services to a Medicaid, full scope of care client along with a secondary surgical intervention, such as lysis of adhesions or Cesarean Section delivery, how do I bill?

CNP clients have full scope of care and are eligible for more than contraceptive intervention only. Submit the claim with a completed, federally approved Sterilization Consent Form for payment.

If you do not have the consent form or it wasn't completed properly or the client was sterilized prior to the 30 days waiting period (client doesn't meet the criteria for HRSA to waive the 30 day waiting period) then the sterilization line on the claim will be denied and the other line items on the claim will be processed for possible payment.

How to Complete the Sterilization Consent Form (DSHS 13-364)?

- All information on the Sterilization Consent Form, DSHS 13-364, must be legible.
- All blanks on the Sterilization Consent Form, DSHS 13-364, must be completed *except* race, ethnicity, and interpreter's statement (unless needed).
- HRSA does not accept "stamped" or electronic signatures.

The following numbers correspond to those listed on the Sterilization Consent Form, DSHS 13-364:

Section I: Consent to Sterilization	
Item	Instructions
1. Physician or Clinic:	Must be name of physician, ARNP, or clinic that gave client required information regarding sterilization. This may be different than performing physician if another physician takes over. <i>Examples: Clinic – ABC Clinic. Physician – Either doctor's name, or doctor on call at ABC Clinic.</i>
2. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
3. Month/Day/Year:	Must be client's birth date.
4. Individual to be sterilized:	Must be client's first and last name. Must be same name as Items #7, #12, and #18 on Sterilization Consent Form, DSHS 13-364.
5. Physician:	Can be group of physician or ARNP names, clinic names, or physician or ARNP on call at the clinic. This doesn't have to be the same name signed on Item # 22.
6. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
7. Signature:	Client signature. Must be client's first and last name. Must be same name as Items #4, #12, and #18 on Sterilization Consent Form, DSHS 13-364. Must be signed in ink.

Item	Instructions
8. Month/Day/Year:	<p>Date of consent. Must be date that client was initially counseled regarding sterilization.</p> <p>Must be more than 30 days, but less than 180 days, prior to date of sterilization (Item # 19). Note: This is true even of shorter months such as February.</p> <p>The first day of the 30 day wait period begins the day after the client signs and dates the consent form, line #8.</p> <p>Example: If the consent form was signed on 2/2/2005, the client has met the 30-day wait period on 3/5/2005.</p> <p>If less than 30 days, refer to page F.2/F.3: "When does HRSA waive the 30 day waiting period?" and section IV of Sterilization Consent Form, DSHS 13-364.</p>
Section II: Interpreter's Statement	
Item	Instructions
9. Language:	Must specify language into which sterilization information statement has been translated.
10. Interpreter:	<p>Must be interpreter's name.</p> <p>Must be interpreter's original signature in ink.</p>
11. Date:	Must be date of interpreter's statement.
Section III: Statement of Person Obtaining Consent	
Item	Instructions
12. Name of individual:	<p>Must be client's first and last name.</p> <p>Must be same name as Items #4, #7, and #18 on Sterilization Consent Form.</p>
13. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
14. Signature of person obtaining consent:	Must be first and last name signed in ink.
15. Date:	Date consent was obtained.
16. Facility:	Must be full name of clinic or physician obtaining consent. Initials are acceptable.
17. Address:	Must be physical address of physician's clinic or office obtaining consent.

Section IV: Physician's Statement	
Item	Instructions
18. Name of individual to be sterilized:	Must be client's first and last name. Must be same name as Items #4, #7, and #12 on Sterilization Consent Form, DSHS 13-364.
19. Date of sterilization:	Must be more than 30 days, but less than 180 days, from client's signed consent date listed in Item #8. If less than 30 days, refer to page F.2/F.3: "When does HRSA waive the 30 day waiting period?" and section IV of the Sterilization Consent Form, DSHS 13-364.
20. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
21. Expected date of delivery:	When premature delivery box is checked, this date must be <i>expected</i> date of delivery. Do not use actual date of delivery.
22. Physician:	Physician's or ARNP's signature. Must be physician or ARNP who actually performed sterilization procedure. Must be signed in ink. Name must be the same name as on the claim submitted for payment.
23. Date:	Date of physician's or ARNP's signature. Must be completed either shortly before, on, or after the sterilization procedure.
24. Physician's printed name	Please print physician's or ARNP's name signed on Item #22.

How to Complete the Sterilization Consent Form for a Client Age 18-20

1. Use Sterilization Consent Form, DSHS 13-364(x).
2. Cross out "**age 21**" in the following three places on the form and write in "**18**":
 - a. Section I: Consent to Sterilization: "**I am at least 21...**"
 - b. Section III: Statement of Person Obtaining Consent: "**To the best of my knowledge... is at least 21...**"
 - c. Section IV: Physician's Statement: "**To the best of my knowledge... is at least 21...**"



SAMPLE STERILIZATION CONSENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

SECTION I: CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

(1) Dr. Tim Lu
Physician or Clinic

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Aid to Families with Dependent Children (AFDC) or Medicaid, that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children, or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a

(2) tubal ligation The discomforts, risks, and
Specify type of operation

benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally-funded programs.

I am at least 21 years of age and was born on (3) August 1, 1971
Month Day Year

I (4) Jane Doe hereby consent of my own
Individual to be sterilized

free will to be sterilized by (5) Dr. Tim Lu
Physician

by a method called (6) tubal ligation My consent
Specify type of operation

expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) _____ (8) August 20, 2001
Signature Month Day Year

You are requested to supply the following information, but it is not required. *Race and ethnicity designation (please check):*

- ☒ American Indian or Alaska Native ☐ Black (not of Hispanic origin)
☐ Hispanic
☐ Asian or Pacific Islander ☐ White (not of Hispanic origin)

SECTION II: INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the

consent form in (9) _____ language and explained
Language

its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ (11) _____
Interpreter Date

SECTION III: STATEMENT OF PERSON OBTAINING CONSENT

Before (12) Jane Doe signed the consent form, I
Name of individual

explained to him/her the nature of the sterilization operation,

(13) tubal ligation the fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) _____ (15) August 20, 2001
Signature of person obtaining consent Date

(16) US Clinic
Facility

(17) PO Box 123, Anywhere, WA 98000
Address

SECTION IV: PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

(18) Jane Doe (19) October 1, 2001
Name of individual to be sterilized Date of sterilization operation

I explained to him/her the nature of the sterilization operation

(20) tubal ligation The fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than thirty (30) days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested.)

- ☐ Premature delivery
Individual's expected date of delivery (21) _____
☐ Emergency abdominal surgery (describe circumstances)

(22) _____ (23) October 1, 2001
Physician's Signature Date

(24) Dr. Tim Lu
Physician's Printed Name



STERILIZATION CONSENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

SECTION I: CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

(1) Dr. Tim Lu
Physician or Clinic

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Aid to Families with Dependent Children (AFDC) or Medicaid, that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children, or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a

(2) tubal ligation The discomforts, risks, and
Specify type of operation

benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally-funded programs.

I am at least 21 18 years of age and was born on (3) August 1, 1984
Month Day Year

I (4) Jane Doe hereby consent of my own
Individual to be sterilized

free will to be sterilized by (5) Dr. Tim Lu
Physician

by a method called (6) tubal ligation My consent
Specify type of operation

expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) _____ (8) August 20, 2001
Signature Month Day Year

You are requested to supply the following information, but it is not required.
Race and ethnicity designation (please check):

- ☐ American Indian or Alaska Native ☐ Black (not of Hispanic origin)
☐ Hispanic ☒ Asian or Pacific Islander ☐ White (not of Hispanic origin)

SECTION II: INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the

consent form in (9) _____ language and explained
Language

its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ (11) _____
Interpreter Date

SECTION III: STATEMENT OF PERSON OBTAINING CONSENT

Before (12) Jane Doe signed the consent form, I
Name of individual

explained to him/her the nature of the sterilization operation,

(13) tubal ligation the fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 18 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) _____ (15) August 20, 2001
Signature of person obtaining consent Date

(16) US Clinic
Facility

(17) PO Box 123, Anywhere, WA 98000
Address

SECTION IV: PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

(18) Jane Doe (19) October 1, 2001
Name of individual to be sterilized Date of sterilization operation

I explained to him/her the nature of the sterilization operation

(20) tubal ligation The fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 18 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than thirty (30) days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested.)

- ☐ Premature delivery
Individual's expected date of delivery (21) _____
☐ Emergency abdominal surgery (describe circumstances)

(22) _____ (23) October 1, 2001
Physician's Signature Date

(24) Dr. Tim Lu
Physician's Printed Name

Hysterectomies [Refer to WAC 388-531-1550(10)]

- Hysterectomies are paid only for medical reasons *unrelated* to sterilization.
- Federal regulations prohibit payment for hysterectomy procedures until a properly completed consent form is received. To comply with this requirement, surgeons, anesthesiologists, and assistant surgeons must obtain a copy of a completed DSHS-approved consent form to attach to their claim.
- **ALL** hysterectomy procedures require a properly completed DSHS-approved consent form, regardless of the client's age or the ICD-9-CM diagnosis.
- Submit the claim and completed DSHS-approved consent form to the:

**DIVISION OF PROGRAM SUPPORT
PO BOX 9248
OLYMPIA WA 98507-9248**

Download the Hysterectomy Consent Form [DSHS 13-365] at:

<http://www1.dshs.wa.gov/msa/forms/eforms.html>

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Abortion Services (Drug Induced)

- Methotrexate and misoprostol are two drugs approved by the Food and Drug Administration (FDA) for use in inducing abortions.
 - ✓ J9260 Methotrexate sodium, 50 mg
 - ✓ S0191 Misoprostol, oral, 200 mcg
- When these drugs are used for abortion services, providers must bill using the appropriate ICD-9-CM abortion diagnosis code. Other medical services (laboratory, history/physical, ultrasound, etc.) performed at the time of the drug administration must be billed on the same claim as the abortion drugs.
- Rho(D) immune globulin must be billed using the appropriate HCPCS codes.
- **RU-486 Abortion Drug**

HRSA pays for RU-486 for medically induced abortions provided through physicians' offices using the codes in the following table. Office visits, laboratory tests, and diagnostic tests performed for the purpose of confirming pregnancy, gestational age, and successful termination must be billed on the same claim form as the abortion drugs.

Bill HCPCS Code	Description
S0190	Mifepristone, oral, 200 mg
S0191	Misoprostol, oral, 200 mcg

Abortion centers must be approved by HRSA to be able to bill for facility fee payments. If you would like to become an abortion center provider, fax your request to the program manager at 360.586.1471.

Abortion Center Contracts (Facility Fees)

- For providers who currently have an abortion center contract with HRSA, facility fees are payable only for surgical abortions. Do not bill facility fee charges for drug-induced abortions not requiring surgical intervention. HRSA pays the contractor facility fees for surgical abortion services once per abortion, per eligible client. Clients on the Family Planning Only program are not eligible for abortions. Please refer them to their local Community Service Office to request a change in their eligibility since they are pregnant. Clients enrolled in an HRSA managed care organization can self refer for abortions.
- Contracted facility fee payment includes all room charges, equipment, supplies, and drugs (including anti-anxiety, anesthesia, and pain medications, but excluding Rho(D) immune globulins). **Payment is limited to one special agreement facility fee per client, per abortion.** The facility fee is not payable per visit, even though a particular procedure or case may take several days or visits to complete. The facility fee does not include professional services, lab charges, or ultrasound and other x-rays, which can be billed separately.

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